good paste in eczema is: ℞.—Zinci oxydati, 40; dextrin., aq. destill., āā 20; glycerin., 40; flor. sulph., 2.—M. Make a paste. Another, a mixture of the lead and dextrine pastes is: ℞.—Litharg., 30; aceti, 50; coq. ad 50. Adde, dextrin., aquæ, glycerin., āā 15; antea cocta.—M. Make a paste. If the paste should become too hard when dry, a few drops of hot water may be added.

Gum Pastes.—Unna has recently used gum arabic as a base for medicated pastes, mixed with glycerine and some powder or other, using one part each of mucilage of acacia and glycerine, and two parts of powder. The following are examples of gum pastes:—

℞.—Zinc. oxyd., 40;
Hydrarg. præc. rubri, 2;
Muc. acac.,
Glycerin., āā 20.
M.—Make paste. Eczema of children.

℞.—Zinc. oxydati, 40;
Bals. peruv., 20;
Muc. acac.,
Glycerin., āā 30.
M.—Make a paste. Scabies.

℞.—Cretæ alb.,
Flor. sulph., āā 2;
Picis liquid., 8;
Amyli, 20;
Muc. acac.,
Glycerin., āā 15.

℞.—Zinci oxydat., 50;
Acid. salicyl.,
Acid. carbol., āā 2;
Mucil. acaciæ,
Glycerini, āā 25;
M.—Make a paste.

℞.—Sacchari alb.,
Zinc. oxydat.,
Mucil. acaciæ,
Glycerini, āā 5.
M.—For sore nipples.

℞.—Amyli, 25;
Acid. pyrogal., 5;
Mucil. acac.,
Glycerini, āā 15.
M.—Make a paste.

Lead is best used as acetate of lead alone, or mixed with dextrine paste. Oxide of zinc may be incorporated in bolus, lead, starch, dextrine, and gum pastes. Sulphur mixes well in starch, dextrine, and gum pastes, less so in bolus paste, and should not be used in lead pastes. Preparations of ichthyol mix well in all except the gum pastes; especially well in lead paste. Tar is a useful ingredient in all the different pastes. Naphthol, carbolic acid, chloral hydrate, and camphor mix well in all pastes. Salicylic acid mixes well with all pastes except the gum. Iodine and iodoform mix well in lead, bolus, and gum pastes, but not in starch and dextrine pastes. Sublimate, calomel, white and red precipitate incorporate well in all pastes. Chrysarobin and pyrogallic acid mix best in bolus and gum pastes. Animal, vegetable, and mineral fats, as well as soap, mix in slight quantities without injury to the pastes. Large quantities of these, as well as caustic alkalies, do not agree with the technical and therapeutic characters of the pastes.

SURGERY.

Extirpation of the Larynx.

Surgeon-Major K. McLeod reports the case of a native of Bengal, æt. 40 years, admitted to the hospital on September 13, 1883, suffering from aphonia and dyspnœa and a tumour of the pharynx implicating the larynx. His troubles commenced about a year before his admission, when he was attacked with sore-throat. A painful swelling was noticed at this time, which prevented the swallowing of food; but in a few days a discharge of blood and matter took place, and the swelling and dysphagia disappeared. Some pain however remained, and in about two months he began to bring up small quantities of blood occasionally. A month after this he got an attack of fever, and at this period, about nine months before his admission, he lost his voice. He also began to experience shooting pain behind the right ear; this interfered with his sleep, and he resorted to opium, consuming habitually about three grains of the crude drug. He was under observation for a fortnight in the second physician's ward before his admission into the surgical ward. On admission he was found to suffer from complete loss of voice, being able to talk only in a hoarse whisper. He suffered from considerable difficulty in breathing, and was subject to violent spasmodic fits of cough, resulting in the expectoration of bloody mucus mixed with small quantities of pus. He could open his mouth wide, and on inspecting his pharynx a tumour could be seen on the right side of the faucial aperture, just below the tonsil. It was about the size of a walnut, very vascular, and papillated on the surface. It felt hard, and on introducing the finger the tumour was found to implicate the glottis, the right fold of which felt tuberculated and thickened. The epiglottis was apparently healthy, considerable thickening existed on the right side of the larynx as far down as the cricoid cartilage, but none on the left. The thyroid body was apparently healthy. The box of the larynx moved freely up and down during the act of deglutition, and could also be moved from side to side on the deep tissues of the neck. An enlarged and indurated gland was felt deep beneath the sterno-mastoid.

On Sept. 19th he was put under chloroform, and an incision was made in the middle line of the neck in front from below the chin to within half an inch of the inter-clavicular notch. The muscles were exposed and the sterno-hyoids and omo-hyoids pulled aside, the thyro-hyoids divided close to their thyroideal origin. The larynx was carefully isolated on both sides, and during this process some small vessels had to be tied. The thyroid gland looked healthy, and it was accordingly decided not to remove it. The windpipe was now divided through the cricoid cartilage, and the divided end pulled forwards by a stout double silken thread passed through its anterior margin. Breathing and chloroforming were henceforward carried on through the tracheal opening. Some embarrassment of respiration occurred at the moment of dividing the windpipe, owing to a little blood entering it; but this difficulty was very temporary. The larynx was then rapidly dissected off the pharynx by means of a pair of blunt-pointed scissors, its attachments to the hyoid, tongue, and fauces divided, and the organ removed with the epiglottis, which was thickening at the base. It was then found that the pharynx had undergone considerable infiltration, and that the right lobe of the thyroid was adherent to a mass of cancerous tissue lying to the right of the tube passing under the posterior pharyngeal wall. The mass also implicated the fauces on the right side as far up as the tonsil. The carotid artery could be felt pulsating just outside of this mass. A very careful and tedious dissection was necessary to remove this mass. Preliminary ligation of tissues likely to contain vessels was resorted to, and the scissors used to divide the parts as far beyond the limit of manifest disease as possible. Finally the chain of an écraseur was passed round the attachments of the mass, which was thus severed and taken away.

The indurated gland was then sought for, isolated and removed. A few bleeding points required tying, but the amount of blood lost was not large. The operation occupied about an hour and a half. Directions were given for carefully watching the patient, keeping the wound free of accumulated blood and secretions, and feeding him periodically with nutrient enemata and with milk and beef-tea alternately by means of an elastic catheter passed into the œsophagus.

No dressing was applied except a layer of carbolic gauze to prevent access of dust, etc. A tracheotomy tube to be used at feeding times, but not worn habitually. The tumour was examined after removal, with the following result. The interior of the larynx was healthy. The disease had grown from the pharynx, had involved the root of the epiglottis, and the right aryteno-epiglottidean fold, and spread along the whole surface of the right ala of the thyroid cartilage externally. The pharynx was extensively implicated on the right side, and the tissue lying between it, and the longus colli muscle as far down as the right lobe of the thyroid body, which was adherent to the mass. A microscopic examination of the tumour was made by Dr. D. D. Cunningham, with the following result: "Tissue of embryonic character, consisting in great part merely of fusiform cells, the cells extremely abundant, and in many cases polynucleated ; forms various."

The patient never reacted well, and died on the fifth day after the operation. —*Lancet*, April 26, 1884.

Certain Forms of Intestinal Obstruction that may follow Hernia.

At the meeting of the Harveian Society of London, on March 20th, a paper on this subject was read by Mr. F. Treves. Although, after complete reduction of a strangulated hernia, and after recovery from the operation, as a rule, no further intestinal troubles might be expected, apart from such as depend upon fresh accidents to the rupture, certain forms of intestinal obstruction might follow after such reduction. 1. There might be stricture of the intestine, due to cicatrization after ulceration or sloughing of the mucous membrane, or to a form of contracting peritonitis. From collected cases, it would appear that neither the seat of the hernia, nor the duration of the strangulation, nor the nature of the operation, has certain or definite concern in the production of these strictures. 2. Obstruction might be due to adhesions. The herniated loop might become adherent to the parietal peritoneum, and cause occlusion by "kinking;" or the adhesions might lead to "bands." Omental bands were also common after certain herniæ. 3. Obstruction might be produced by the formation in the bowel of a rigid loop. Several examples of this form of obstruction were given, together with examples of a fistula bimucosa consequent upon injuries received by the strangulated bowel.

Mr. Gant said, with regard to the origin of stricture of the intestine and looped constriction as forms of intestinal obstruction resulting from hernia, that they were not subsequent conditions, but commenced from the time of operation, owing to the indentation often left upon the bowel at the seat of stricture, when the strangulated portion had been inadvertently returned into the abdomen in that condition. Hence the great importance of gently drawing down the gut, and of effacing the indentation by gentle manipulation before returning the part into the abdomen. If this constriction could not be thus relieved, the previous division of the stricture would only half complete the operation, and the prognosis would be proportionately unfavourable. After the reduction of enterocele without operation, it was more than probable that similar forms of intestinal obstruction originated in like manner; and this pathological explanation would indicate the propriety of resorting to operation to discover and release any such constriction, even when reduction could be effected by taxis, provided that the duration of the strangulation rendered it probable that plastic constriction might have supervened. If the bowel were then returned, the symptoms of strangulation would probably continue, or intestinal obstruction eventually result.—*British Med. Journ.*, April 5, 1884.